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ABSTRACT

Jefferson County School District, the largest school district in Colorado, commissioned a study to examine the type and extent of mental health needs of elementary school children, the impact of these needs, and appropriate recommendations for the district. Elementary schools were ranked according to estimated socioeconomic status of the students and 20 representative schools were chosen for the study. Since the high costs of measuring the children's unmet mental health needs were prohibitive, the study focused on educator's perceptions to answer its major questions. Over 400 educators serving as participants included principals, teachers, and the members of each school's Special Education and Related Services team. A questionnaire was used which focused on self-image, relationships with peers and adults, school skills and competencies, and other behavioral/emotional concerns. Participants were also interviewed. Results showed that educators perceived numerous unmet mental health needs involving 15-30 percent of the elementary school students and most felt these needs were increasing. Self-image ranked as the greatest need, followed by interpersonal relationships, and school skills and competencies. It is recommended that the educational community take immediate, bold steps to address the mental health needs of children. (ABL)

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Elementary School Children's Mental Health Needs: Educators' Perceptions and Implications for Practice

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Elementary School Children's Mental Health Needs:

Educators' Perceptions and Implications for Practice

The purpose of this paper is to describe an extensive survey of educators in a large metropolitan school district in terms of their perceptions of the unmet mental health needs of elementary school children in the district. The impetus for the survey was an external audit of the district's Student Guidance Services Program. The visiting audit team found services well in place for secondary school students, but not at the elementary level (the district does not have elementary school counselors). The team recommended that the district initiate a quality developmental preventative elementary counseling program.

District officials considered that such a response would lack financial feasibility, given current budget constraints. However, the district did commission us to do a study in 1987 to answer three central questions:

(1) What are the type and extent of the unmet mental health needs of elementary school children in the district?

(2) How do these unmet needs impact the effectiveness of the children's school teachers?

(3) What recommendations are appropriate for practitioners in the district (in light of the answers to the first two questions)?

The district also provided a broad definition to guide the study. Mental health needs were defined as those needs related to the development of a positive self image, to building healthy relationships with peers and adults, and to acquiring the skills that enable one to function appropriately in the school setting. While broad and school-based, this definition corresponds well with the general breadth of mental health definitions (e.g., Dougherty, Saxe, Cross, & Silverman, 1987).

Method

Sample

Jefferson County School District, the largest in Colorado with its K-12 enrollment of 75,000 students, served as the site for the study. The district encompasses a wide, diverse geographic area which includes established smaller towns, newer still-expanding suburbs, and mountain communities. While the student population represents all socioeconomic levels, the county is predominantly white (about 95%) and middle-class (e.g., the median household income of $41,000 was third highest in Colorado in 1986). School served as the sampling unit. Of the district's 79 schools serving elementary students, 2 were excluded as unrepresentative as they were small in enrollment and served both elementary and secondary students with pronounced special needs. To add precision to the study's design, we desired to estimate each school's socioeconomic status (SES) without collecting traditional indices, a process that would have been laborious and potentially reactive. Since the district participated in the federally sponsored free and reduced-cost lunch program with qualifications based on family income and size, we decided to use data from the program as a proxy for SES.

We operationalized this variable by determining for each school the number of children obtaining free lunch and then adding one-half the number of students receiving reduced-cost lunch (this "one-half" weighting was arbitrary). The resultant total was divided by the school's enrollment to determine a percentage figure; these figures varied from over 50% to just above 1%. The 77 schools were rank-ordered from 1 (53%) to 77 (1%) based on the proxy for SES (hereinafter referred to as SES for simplicity). Schools then were formed into quadrants; ranks 1 to 20 in the first (lowest) SES quadrant and 19 schools in each of the other three groupings.

Five schools were randomly selected from each quadrant to form the sample for the study. First, second, and third "replacement" schools also were randomly sampled from each of the four SES quadrants in case any of the originally selected schools were unable or

unwilling to participate. After notification by letter and phone, principals of 19 of the 20 schools agreed to take part. One school dropped out of the original sample due to a disruptive set of circumstances that resulted in a change of principals. The principal of the first replacement school for that SES quadrant was contacted and agreed to participate.

Instrumentation

This study focused on educators' perceptions to answer its major questions. While measuring children's unmet mental health needs directly was appealing, the psychometric difficulties and high costs involved were viewed as prohibitive. Instead, the educators' perceptions were collected using questionnaires primarily and interviews secondarily.

A questionnaire was designed specifically for this study, using the school district's definition of mental health as a central influence. Initially, the questionnaire consisted of 74 behaviors/characteristics, grouped into four domains: self-image, relationships with peers and adults, school skills and competencies, and other behavioral/emotional concerns. For each characteristic or behavior listed, four separate five-point rating scales were used to obtain respondents' perceptions of the seriousness of the behavior in a particular school; its prevalence; its impact on teacher effectiveness; and the extent to which students with the behavior were having their needs met. A variety of sources was examined in developing this initial draft, including: published research studies that showed measures of students' behaviors related to mental health (e.g., Cohen, 1976; Lorion, Caldwell, & Cowen, 1976; Wickman, 1928); published instruments that measure child behaviors associated with mental health [e.g., the Bristol Social Adjustment Guides (Stott & Marston, 1970) and the Behavior Rating Profile (Brown & Hammill, 1983)]; unpublished instruments collected by the researchers over many years; reports from the external audit of the district's guidance services program; and the

researchers' own notions of potentially relevant items.

The draft questionnaire was pilot-tested with a few graduate students and with 10 teachers in the district. Their constructive criticism led to a revision of the instrument. It was shortened from 74 to 48 items grouped into four subscales: self-image, 10 items; relationships with peers and adults, 11 items; school skills and competencies, 15 items; and other behavioral/emotional concerns, 12 items. Each item involved two five-point rating scales: one that respondents used to estimate the percentage of students in their school exhibiting the behavior/characteristic regularly; and the other that they used to indicate how much the behavior/characteristic interfered with the teacher's effectiveness. A third aspect of this section of the questionnaire directed respondents to circle any of the 48 behaviors/characteristics not currently given adequate attention in their school (i.e., those that represented unmet mental health needs). Following the list of 48 behaviors/characteristics was a number of separate items and open-ended questions. These solicited opinions related to the most serious mental health needs, whether they were increasing or decreasing in frequency, the amount of support from the district in meeting the needs, causes of the mental health needs, and suggestions for programs or other solutions to meet the needs.

An interview schedule also was developed to preclude relying only on numerical analyses of questionnaire responses. It was believed that interviews would "vitalize" the questionnaire data by adding a qualitative dimension. The schedule purposely was kept simple and unstructured. The stimulus questions focused on educators' perceptions of the seriousness of the children's maladaptive behaviors, what major effects such behaviors had on teachers, whether such behaviors were increasing in frequency, the causes of students' mental health needs, ideas on how the needs might be met, and how prepared the interviewees felt to deal with these student problems.

Using data subsequently collected from the study participants, internal consistency reliability (KR_{20}) of the questionnaire was estimated for each of the four subscales, for each response scale (percent of students displaying the behavior/characteristic, extent of interference with teacher effectiveness, and extent needs were inadequately attended to). Resultant reliability coefficients ranged from .79 to .92, with a median coefficient of .89.

Procedures

Questionnaires were given to all certified personnel in each of the 20 sample schools. Thus, respondents included principals, teachers (classroom, special subject, special education, and Chapter I), and the members of each school's Special Education and Related Services (SERS) team (typically a school psychologist and/or social worker, an educational specialist, a speech/language specialist, and a school nurse). Questionnaires were delivered or mailed to arrive a week before the interviews were conducted, and were collected prior to the interviews. The questionnaire return rate was higher than anticipated, 80%, or 517, in all.

Three interviews were conducted by the researchers or two of their graduate assisstants at each of the sample schools. The principal was interviewed separately, as was the SERS team joined by a randomly selected special education teacher. The third interview involved a group of eight teachers, one selected randomly from each grade level (K-6) and one selected randomly from the school's special subject teachers. On average, interviews lasted 40 to 45 minutes.

Data Analysis

The primary statistical analyses were descriptive. Frequencies and percentages were calculated for the questionnaire data, as well as means and standard deviations for the interval- and ratio-level variables. Secondarily, one-way analyses of variance (ANOVA) and chi-square tests were run on certain questionnaire items by demographic variables--i.e., by position (principal, teacher, SERS member), by SES level, and by grade level. The open-ended

questionnaire items and the interview data were content-analyzed and summarized descriptively.

Results

A tremendous amount of data was generated in the study, so only selected aspects of it are now reported and discussed. Further, given the close (and comforting) correspondence between the results of the two methods, that is, questionnaire and interview, we principally report the questionnaire data here. We present data focusing on the nature, prevalence, and seriousness of elementary school children's mental health needs, the impact of such needs on teachers, and on the perceived causes and proposed solutions to such needs.

Children's Mental Health Needs: Nature, Prevalence, and Seriousness

Data pertinent to the nature and prevalence of children's mental health needs are presented in Tables 1 through 4. Each table represents one of the four subscales. Collectively, they display responses to several key questions about the 48 student behaviors/characteristics. In general, via the interviews, it was discerned that the educators perceived numerous unmet mental health needs, involving 15 percent to 30 percent of the elementary school children (with at least one, and frequently more, of the behaviors/characteristics).

Table 1 reports data related to respondents' perceptions of children's mental health needs related to self-image. The first two columns of the table present the numbers and percentages of the 517 respondents who circled the behavior/characteristic, indicating that they believed that it was not being given adequate attention in their school. Thus, these results reflect the type and extent of respondents' perceptions of children's unmet mental health needs. Further, the 10 behaviors/characteristics in the self-image domain have been ordered by relative frequency. Therefore, the first item in Table 1, "have poor self-image, make negative self-statements," was circled by 140 or 27.2% of the respondents. Conversely, the least selected characteristic in that subscale--"are oversensitive"--was circled by only 7.4% of the educators.

Tables 2, 3, and 4 are read in an analogous fashion.

A second type of information in Tables 1 to 4, found in the two right-hand columns, consists of means and standard deviations from the question concerning percentage of students displaying each behavior/characteristic. Essentially these constitute the respondents' average perception of the frequency of occurrence of each behavior/characteristic. The average response for the first item in Table 1 was 2.69; thus, educators considered having a poor self-image and making negative self-statements as typical for "a few" to "some" (possibly 15%) of their students.

Another questionnaire item addressed the perceived seriousness of mental health needs. Respondents were directed to select the 5 behaviors/characteristics (from the 48 listed) which they considered most serious. Table 5 contains the results. At least one behavior/characteristic was listed by 486 of the 517 respondents, and most of them listed the five allowed. Thus, "have poor self-image, make negative self statements) was selected by 158 or 32.5% of the 486 respondents. The "top eight" behaviors/characteristics, each selected by at least 20% of the respondents, were divided fairly evenly among the questionnaire's three major subscales. Three (actually all from the "top five") were from the 'self-image" subscale, three from the "school skills" subscale, and two from the "relationships" subscale.

Two other questionnaire items pertained to the prevalence and seriousness dimensions. On one, educators rank-ordered the three major subscales in terms of students' needs in their schools. Results made it clear that self-image was viewed as the greatest mental health need area by a majority of respondents (56.6%), followed by interpersonal relationships (30.6%) and school skills/competencies (12.8%). A second item asked whether children's mental health needs were increasing or decreasing in frequency. A five-point rating scale ("definitely decreasing" to "definitely increasing") was used. About 50% of the respondents chose "definitely increasing," 35% selected "probably increasing," and 20% were "unsure;" only 5%

chose either "probably decreasing" or "definitely decreasing."

Children's Mental Health Needs: Impact on Teacher Effectiveness

The middle columns of Tables 1 through 4 report means and standard deviations for the 48 student behaviors/characteristics in terms of respondents' perceptions of how much the behavior or characteristic interfered with the teacher's ability to teach effectively. Therefore, in Table 1, the initial behavior -- "have poor self-image, make negative self statements"--was viewed as moderately interfering with teacher effectiveness, in that it received an average rating of 2.80 (on a scale where 2 corresponded to "slight" and 3 conveyed "moderate interference").

One interview question, "What are the major effects on teachers of these problems or maladaptive behaviors?", directly addressed this topic. In Table 6, note that 75% of the teacher groups and an even larger proportion of the SERS groups reported frustration, stress, and/or "burnout." Reduced time for instruction was noted by over half of the groups, and so forth.

Children's Mental Health Needs: Perceived Causes and Proposed Solutions

On the questionnaire, an open-ended question asked respondents to identify the causes responsible for their elementary school childrens' mental health needs. In all, 480 educators gave 1,038 responses. Table 7 contains the categories resulting from a content analysis. Unstable homes was the single most frequently cited cause (over 22% of all the responses written-in). In fact, the predominant categories that emerged involved home and family variables. Unstable homes, parental underinvolvement, divorce/single-parent homes, poor parenting skills, family economic problems, high mobility, parent overinvolvement, low valuing of education, poor role models, and child abuse/neglect accounted for, in total, nearly 80% of the responses given.

Another open-ended item on the questionnaire directed respondents to identify alternatives, solutions, or programs which they believed would best meet the mental health

needs of their elementary school children. In all, 758 responses were provided by 424 educators. The content analysis of the responses resulted in numerous categories as shown in Table 8. Over 35% of the responses concerned the provision of more resources to current programs (e.,g., SERS), of resources for new initiatives (e.g., counselors), or of redirected resources (e.g., less assessment and more prevention or intervention). Two other ideas mentioned frequently involved affective-focused activities (e.g., one-issue counseling groups and classroom meetings on affective relationships and problem solving) and parent education programs.

Discussion and Implications for Practice

Three limitations of this study should be kept in mind in interpreting these results. First, our data base was generated from a random sample of about one-quarter of the elementary schools in one large Colorado school district; the questionnaire response rate was 80%. Thus, the data may be incomplete or biased in some unknown ways due to the 20% nonresponse rate. We consider that such biases likely are small, particularly given the close correspondence between the questionnaire and interview data. Nevertheless, the study's findings should be generalized cautiously. Second, the study and instrument construction was guided by the district's tripartite definition of "mental health needs." There certainly could be some discontinuity between the 48 behaviors/characteristics that survived the questionnaire development process and the abstract concept "mental health." Third, the study involved perceptions of children's mental health needs, rather than attempting to measure such needs directly. Despite the certainty of some discrepancy between the respondents' perceptions and reality, it is important to be mindful that perceptions are powerful determinants of behavior.

Overall, this study demonstrated that the district educators perceived numerous unmet mental health needs involving 15% to 30% of the elementary school students, and most respondents sensed such needs as increasing. Self-image was denoted as the greatest need

area, followed by interpersonal relationships, and then school skills and competencies.

It is of interest to note which behaviors/characteristics were identified most often by the educators as not receiving adequate attention in their schools and, thus, which might represent unmet mental health needs. Across Tables 1 through 4, the "top 12" problem behaviors/characteristics (all selected by at least 20% of the respondents and in order of how frequently selected) were:

1. Have poor decision-making/problem solving skills
2. Have poor self-image, make negative self-statements
3. Have low self-confidence, avoid the difficult
4. Are unable to resolve interpersonal conflicts
5. Are depressed, unhappy
6. Are overly influenced by peers, have poor refusal skills
7. Are manipulative, controlling
8. Have poor study and planning skills
9. Lack motivation
10. Cannot concentrate, inattentive, off-task
11. Are disobedient, disrespectful, stubborn
12. Are argumentative, verbally abusive

Examination of Table 5 reveals that 9 of the 12 behaviors listed above were also viewed as most serious by the respondents. Further, the two right-hand columns in Tables 1 through 4 make it clear that the "top 12" behaviors/characteristics were also the ones that educators considered to be most commonly displayed by students. The average "extent of students displaying" rating for these 12 items was 2.75, while it was 2.23 for the other 36 behaviors/characteristics. More important, these "prevalence" data show that most of the 48 behaviors were perceived as being displayed regularly by "a few" to "some" students. The data

do not yield exact percentages of students, but they do afford rough estimates--i.e., between 10% and 20% of the students were perceived to display regularly most of the "top 12" behaviors. Additional analyses (ANOVAs) on the ratings revealed that special education teachers tended to give significantly higher avergage "extent" ratings, for many of the items, than did other respondent groups. Also, the respondents from low and low-middle SES schools often perceived significantly larger percentages of students displaying the behaviors/characteristics regularly, as compared to respondents from higher SES schools.

Turning to the question of how these unmet mental health needs impact teacher effectiveness, the middle two columns of Tables 1 to 4 become relevant. Across the four tables, those behaviors/characteristics that received the highest interference ratings (in order, starting with the highest) were:

1. Disrupt class, talkative, noisy
2. Cannot concentrate, inattentive, off-task*
3. Lack motivation*
4. Are disobedient, disrespectful, stubborn*
5. Are argumentative, verbally abusive*
6. Display anger, provoke anger in others
7. Have poor decision-making/problem-solving skills*
8. Are manipulative, controlling*
9. Have poor study and planning skills*
10. Fail to complete work or to do homework
11. Are unable to resolve interpersonal conflicts*
12. Are impulsive, overactive
13. Have low self-confidence, avoid the difficult*
14. Are physically aggressive, violent, fight/bully

15. Are overdependent, seek help constantly

16. Have poor self-image, make negative self statements*

17. Are overly influenced by peers, have poor refusal skills*

In the list above, the 11 behaviors/characteristics asterisked also were in the "top 12" unmet need list. In general, then, those behaviors/characteristics viewed as most interfering were also considered most likely unmet or neglected. The interference ratings for the 17 items above ranged from 3.34 to 2.80; thus, on average, they were perceived as moderately interfering with teacher effectiveness. Statistical tests generally revealed higher interference ratings for these behaviors by special education teachers, by teachers in grades 3 to 6 (as compared with K-2 teachers), and by educators working in low and low-middle SES-level schools.

Interview data as shown in Table 6 were also pertinent to this question. They revealed that the impact on teachers from coping with their students' unmet mental health needs was viewed as tripartite: personal (e.g., frustration, stress, "burnout", discouragement); professional (e.g., worries about reduced instructional time, pressure to teach the curriculum, limited time available for better adjusted students); and system-oriented (e.g., concerns about inadequate parental and administrative support, expectations that teachers should act as counselors). Most groups interviewed indicated that teachers either felt unprepared to deal with their students' mental health needs or felt prepared but lacked the necessary time.

The data presented in Tables 7 and 8 offer some interesting suggestions about possible causes for the children's mental health needs, and also recommendations about solutions. Approximately 80% of the perceived causes (Table 7) were parent- or home-related, while school-based problems (e.g., large class size; too much curriculum to cover) accounted for less than 5% of the responses. However, only about 20% of the proposed solutions (Table 8) directly involved parents. These included such suggestions as establishing better support from parents and the community, and parent education programs. The clear majority of the

proposed solutions were school-linked--such as more resources for current programs, new initiatives or redirected resources, and one-issue counseling groups or affective education programs. In our view, the data portray a sharp imbalance. That is, while educators typically viewed children's mental health needs as due to parents and home conditions, they usually did not focus on or include parents in their proposed solutions. One might argue that such an orientation is due to educators' awareness that schools and teachers generally cannot directly change or operate upon the perceived causes, parents and home conditions. Be that as it may, this imbalance likely should not be quickly disregarded.

The study has a number of implications for educators, counselors, and others in the helping professions. One major implication for this district--and the sizable number like it around the country--is to give high priority to mental health as a district goal, and to provide or redirect resources to support that goal. Although finding or redirecting resources is a difficult issue for most districts, the seriousness of the problem warrants at least a close scrutiny of ways that existing resources might be targeted differently. A related issue that arose in many interviews was directly linked to this suggestion--that is, whether the schools should be responsible for mental health, affective education, latch-key children, and other concerns about home conditions. Our orientation is in agreement with Bronfenbrenner (1986), who asserted that schools must be involved in these areas. If schools are to achieve any of their important goals, it seems imperative that students (and teachers) experience positive mental health. Attention to mental health of children in elementary schools, via preventive activities such as a developmental preventative elementary counseling program (Gibson, Mitchell, & Higgins, 1983), likely will pay large dividends in later school and societal settings.

This focus on children's mental health as a system goal might take any number of forms. Often during data collection and analysis, our impression was that the respondents' perception of "the curriculum" and expectations related to it centered on cognitive-domain outcomes, an

understandable orientation given this society's current conception of schools' major responsibility. Still, curriculum demands can present major difficulties for many students; if experiencing failure regularly, a child can develop a negative self-image. A mental health focus could allow addressing this affective concern without abandoning important cognitive objectives for students, by acknowledging the large effect that positive affect can have on learning in general. Cooperative learning (Johnson & Johnson, 1975) is one such way, while related ideas such as team competition on achievement tasks also show promise (e.g., Slavin, 1983, 1987, 1988). Further, the actual curriculum content might be examined. Surveying the "top 12" list of unmet mental health needs, we wonder which content area, grade, or program takes responsibility for students': decision-making and problem-solving skills; interpersonal conflict resolution skills; refusal skills; and study and planning skills. These needs have rather direct curriculum implications and it would seem that responsibility for them should be clearly assigned. Other forms that emphasis on mental health could take might well be more directly affective, such as group counseling sessions, classroom meetings, and a dynamic program of inservices to support educators in their efforts to address childrens' mental health needs.

Another major implication or recommendation of the study was that the locus of control for mental health activities be placed at the school building level, rather than in a district-level office. Many promising suggestions for better meeting children's mental health needs were school-specific. Examples included having a "listener of the day" within the building, or workshops on particular concerns within one school, and reducing "teacher transiency" to enhance school continuity and consistency. Accompanying this recommendation is the suggestion that the school principal (working closely with teachers, counselors if available, and SERS personnel) be the primary person responsible for developing and implementing his/her school's mental health program. We believe that the principal should be as much responsible for each child's mental health as she or he is for each child's academic health. Closely related

to this, we view the principal as excellently positioned to effectively counter a syndrome identified by many respondents as characteristic of a significant number of students--namely, apathy and disinterest in essentially all school-type tasks and activities. This mental health need of "impoverished motivation" can be ameliorated, we believe, by the principal (and counselors, if available) working with the school staff to understand and apply the research on the importance of children having a sense of agency, to see themselves as a principal determinant of their life experiences (e.g., de Charms, 1976; Rotter, 1954; Weiner, 1980).

Yet a final major implication, in our opinion, is that there must be a vigorous rededication by schools, educators, counselors, and others to the principle of involving parents (or whoever fills that role) in their children's education. Both questionnaire and interview data typically focused on parent- and home-related factors as the major causes of children's mental health needs. At the same time, parent education received some support as a potential solution to such needs. Clearly the related issues of parent education and parent involvement in the schools are complex ones (Becher, 1986; Hoover-Dempsey, Bassler, & Brissie, 1987), and we are mindful of many of our respondents' view that "the parents who really need education and need to get involved don't show up."

Still, even if past efforts at parent education and parent involvement have been disappointing, we believe (like Henderson, 1988) that schools should again examine and rethink these critical matters. Literature denoting national demographic trends such as increasing numbers of unstable families, latch-key children, and poverty-linked families with children (e.g., Halpern, 1987; Morrison, 1986; Powell, 1987; Scarr & Weinberg, 1986) makes such a requirement imperative. At a very minimum, schools should interact extensively with those parents who already have decided to be involved with the school. Beyond this, much needs to be done to involve and educate the reluctant or resistant parents. For this latter group, possibly restructuring or expanding educators' traditional concept of parent involvement might be an

appropriate starting point. For example, procedures might be designed to involve single parents and parents who are both working by specific, direct, and (on occasion) short-term tasks. Evening and weekend availability of educators could send positive signals to parents unavailable during normal school hours. Timely and accurate communication with all parents could play an important role in this overall effort.

Believing that the mental health needs of children in this society are increasing (also see Dougherty, 1988, and Tuma, 1989) prompts us to encourage the educational community to take immediate, bold steps to address the issues involved. School principals and counselors should take lead roles in such deliberations and in subsequent operational activities.

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TABLE 1: Educators' Perceptions of Elementary School Children's "Self-Image" Mental Health Needs: By Extent Inadequately Attended To, Extent of Interference with Teacher's Effectiveness, and Extent of Students Displaying.

Unmet Mental Health Need (Student Behavior/Characteristic)	Educators Noting Inadequate Attention To		Extent of Interference with Teacher		Extent of Students Displaying	
	N	%	$\bar{X}$ [a]	s	$\bar{X}$ [b]	s
Have poor self-image, make negative self statements	140	27.2	2.80	1.04	2.69	.98
Have low self-confidence, avoid the difficult	139	27.0	2.94	.99	2.86	.94
Are depressed, unhappy	135	26.2	2.65	.97	2.42	.81
Are overdependent, seek help constantly	92	17.9	2.92	.99	2.62	.92
Are lethargic, passive, apathetic	84	16.3	2.50	1.00	2.26	.79
Are shy, timid, withdrawn	73	14.2	2.23	.79	2.21	.60
Are sullen, moody, pouty	52	10.1	2.62	.96	2.35	.77
Are unassertive, don't stand up for self	45	8.7	2.14	.79	2.23	.73
Are dissatisfied with own performance, overly critical	39	7.6	2.37	.93	2.35	.83
Are oversensitive	38	7.4	2.44	.84	2.47	.83

[a] Scale: 1= None; 2= Slight; 3= Moderate; 4= Substantial; 5= Extreme
[b] Scale: 1=0% (None); 2= 1-10% (A few); 3= 11-20% (Some); 4= 21-50% (Many); 5= Over 50% (Most)

TABLE 2: Educator's Perceptions of Elementary School Children's "Relationships with Peers and Adults" Mental Health Needs: By Extent Inadequately Attended To, Extent of Interference with Teacher's Effectiveness, and Extent of students Displaying.

Unmet Mental Health Need (Student Behavior/Characteristic)	Educators Noting Inadequate Attention To		Extent of Interference with Teacher		Extent of Students Displaying	
	N	%	$\bar{X}$ [a]	s	$\bar{X}$ [b]	s
Are unable to resolve interpersonal conflicts	138	26.8	3.01	1.04	2.76	.97
Are overly influenced by peers, have poor refusal skills	129	25.0	2.80	1.02	2.78	.98
Are manipulative, controlling	125	24.3	3.03	1.04	2.70	.88
Are disobedient, disrespectful stubborn	117	22.7	3.11	1.15	2.56	.90
Are argumentative, verbally abusive	107	20.8	3.09	1.16	2.55	.91
Are introverted, loners, have few friends	100	19.4	2.18	.81	2.09	.54
Display anger, provoke anger in others	98	19.0	3.08	1.13	2.51	.86
Are physically aggressive, violent, fight/bully	92	17.9	2.94	1.21	2.27	.79
Are selfish, self-centered	71	13.8	2.76	.99	2.79	.93
Are suspicious, not trusting	30	5.8	2.21	.91	2.10	.78
Are unsociable, unfriendly	29	5.6	2.16	.90	2.01	.72

[a] Scale: 1= None; 2= Slight; 3= Moderate; 4= Substantial; 5= Extreme

[b] Scale: 1=0% (None); 2= 1-10% (A few); 3= 11-20% (Some); 4= 21-50% (Many); 5= Over 50% (Most)

TABLE 3: Educators' Perceptions of Elementary School Children's "School Skills and Competencies" Mental Health Needs: By Extent Inadequately Attended To, Extent of Interference with Teacher's Effectiveness, and Extent of Students Displaying.

Unmet Mental Health Need (Student Behavior/Characteristic)	Educators Noting Inadequate Attention To		Extent of Interference with Teacher		Extent of Students Displaying	
	N	%	$\bar{X}$ [a]		$\bar{X}$ [b]	s
Have poor decision-making/problem-solving skills	162	31.5	3.05	.98	3.03	.98
Have poor study and planning skills	124	24.1	3.03	1.03	3.00	1.05
Lack motivation	123	23.9	3.14	1.08	2.86	.97
Cannot concentrate, inattentive, off-task	118	22.9	3.15	.99	2.74	.86
Disrupt class, talkative, noisy	101	19.6	3.34	1.02	3.05	.97
Fail to complete work or to do homework	80	15.5	3.02	1.03	2.78	.92
Display low achievement (high ability)	72	14.0	2.79	1.05	2.39	.84
Have attendance problems, truant	44	8.5	2.28	1.13	1.95	.74
Appear unchallenged (high ability)	40	7.8	2.18	1.04	1.87	.70
Whine, tattle	37	7.2	2.70	.93	2.75	.91
Display low achievement (low ability)	36	7.0	2.65	.91	2.43	.76
Participate little in class discussions/activities	34	6.6	2.48	.87	2.45	.80
Daydream	33	6.4	2.56	.87	2.54	.81
Cheat	22	4.3	2.30	.85	2.29	.75
Pass notes in class	5	1.0	1.96	.90	2.07	.90

[a] Scale: 1= None; 2= Slight; 3= Moderate; 4= Substantial; 5= Extreme

[b] Scale: 1= 0% (None); 2= 1-10% (A few); 3= 11-20% (Some); 4= 21-50% (Many); 5= Over 50% (Most)

TABLE 4: Educators' Perceptions of Elementary School Children's "Other Behavioral/Emotional Concerns" Mental Health Needs: By Extent Inadequately Attended To, Extent of Interference with Teacher's Effectiveness, and Extent of Student Displaying.

Unmet Mental Health Need (Student Behavior/Characteristic)	Educators Noting Inadequate Attention To		Extent of Interference with Teacher		Extent of Students Displaying	
	N	%	$\bar{X}$ [a]	s	$\bar{X}$ [b]	s
Are impulsive, overactive	95	18.4	2.97	1.01	2.54	.80
Are anxious, nervous, tense	94	18.2	2.52	.97	2.37	.82
Display irrational, bizarre behavior	73	14.1	2.58	1.38	1.87	.73
Exhibit poor hygiene, uncleanliness	63	12.2	2.05	.92	2.00	.77
Swear, use foul language	61	11.8	2.42	1.00	2.35	.93
Are willful, destructive	60	11.6	2.33	1.13	1.90	.69
Lie	50	9.7	2.60	.93	2.34	.78
Make unusual emotional responses to stimuli	40	7.8	2.19	1.08	1.85	.70
Steal	38	7.4	2.38	1.04	1.97	.62
Show inappropriate sexual behavior (obscene notes/drawings, etc.)	37	7.2	1.94	1.06	1.67	.67
Show evidence of eating disorders	27	5.2	1.54	.74	1.50	.64
Display substance use/abuse (tobacco, alcohol, drugs, other)	14	2.7	1.40	.88	1.25	.54

[a] Scale: 1= None; 2= Slight; 3= Moderate; 4= Substantial; 5= Extreme

[b] Scale: 1= 0% (None); 2= 1-10% (A few); 3= 11-20% (Some); 4= 21-50% (Many); 5= Over 50% (Most)

TABLE 5: Educators' Perceptions of the Seriousness of Unmet Mental Health Needs (Student Behaviors/Characteristics)

Unmet Mental Health Need (Student Behavior/Characteristic)	Educators Selecting as One of Five Most Serious	
	N[a]	%[a]
Have poor self-image, make negative self statements	158	32.5
Have poor decision-making, problem-solving skills	145	29.8
Are unable to resolve interpersonal conflicts	120	24.7
Have low self-confidence, avoid the difficult	117	24.1
Are depressed, unhappy	113	23.3
Are disobedient, disrespectful, stubborn	107	22.0
Lack motivation	104	21.4
Disrupt class, talkative, noisy	97	20.0
Are overly influenced by peers, have poor refusal skills	93	19.1
Are physically aggressive, violent, fight/bully	90	18.5
Cannot concentrate, inattentive, off-task	87	17.9
Display irrational, bizarre behavior	83	17.1

[a]Note: 486 educators responded with up to five behaviors; indicated are the number and percent of the 486 who selected the behavior among their five most serious.

TABLE 6: Group Response by Position to "What Are the Major Effects on Teachers of These Problems or Maladaptive Behaviors?"

Effects on Teachers	Teacher Groups (N=20)	SERS Groups (N=20)	Principals (N=20)
Frustration, stress, "burnout"	15	17	11
Reduced instructional time	12	12	8
Feeling of lack of parental support	6	6	2
Despair, hopelessness, discouragement	6	4	3
Reduced attention to better adjusted children	6	NM	1
Expectations that teachers should be counselors	5	3	NM
Feeling of failure, ineffectiveness, inadequacy	5	NM	3
Feeling of pressure to teach curriculum	3	4	4
Fear of lawsuits, repercussions	2	3	NM
Reduced commitment to education (maintaining, waiting until retirement)	2	NM	3
Feeling of inadequate support from administration	2	1	1

Note: NM = Not mentioned by group.

TABLE 7: Educators' Perceptions of the Causes of Elementary School Students' Mental Health Needs

Perceived Causes	Responses Given N[a]	Responses Given %[a]
Unstable homes (dysfunctional families, poor family life, parental substance abuse)	229	22.1
Parental underinvolvement with children (lack of supervision, time and/or support)	155	14.9
Divorce, single-parent homes	135	13.0
Poor parenting skills (weak discipline, lack of routine/stucture at home, poor parent-child relationships)	106	10.2
Economic problems of parents	52	5.0
School-related problems (large class size, too much curriculum)	43	4.1
Transience, high mobility	40	3.9
Parental overinvolvement with children (over-indulgent, overpressuring, rescuing)	36	3.5
Influence of television	32	3.1
Low value placed on education (parent not supportive of school, loss of respect for school)	26	2.5
Poor role models	21	2.0
Peer pressure	19	1.8
Child abuse and neglect	16	1.5
Miscellaneous/other	128	12.3
Totals	1,038	99.9

[a]Note: 480 educators wrote in a total of 1,038 responses.

TABLE 8: Educators' Proposed Solutions to Meet Elementary School Students' Mental Health Needs

Proposed Solutions	Responses Given N[a]	% [a]
More resources to current programs (e.g., increase SERS time, more SIEBD classes)	142	18.7
New program resources (e.g, elementary counselors) or redirected resources (e.g., less assessment)	133	17.5
One-issue counseling groups, classroom meetings, affective education	105	13.9
Parent education programs	102	13.5
Smaller class size	49	6.5
Improved school climate (e.g., school oriented toward mental health of students and teachers, more positive reinforcement)	41	5.4
Increased support from parents and community	39	5.1
Inservice training for teachers	33	4.4
Change of academic expectations	24	3.2
Services to nonhandicapped children	21	2.8
Extended school programs (before and after school, summer school)	12	1.6
Other solutions	57	7.5
Totals	758	100.1

[a]Note: 424 educators wrote-in a total of 758 responses.